**Open House Plus 2013**

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Post event Evaluation

**Headlines from Open House 2013**

We had 153 people sign in at the event (not all attendees will have done so)

 We had no questions posted on the question wall.

Anecdotally – it was reported that all stall holders were very engaged and keen to share their practice/good news stories and the people found the presentation By Interim Executive Director – John Bolton very useful and informative.

**Evaluations:**

The first completed evaluation to be drawn from the box was Jayne Nicholls from the Occupational Therapy Team, A voucher is on its was to her – Congratulations Jayne

**Overall opinion of this event?**

Delegates were asked to circle up to four words which best described their overall opinion of the event

**Opportunity to Participate**

**Please Use this space to provide further information for the areas above that you have rated very poor or poor**

I felt it was very informative and very well laid out. Lots of information to take away
Venue is too cold, parking is good, good spacious room

**What elements of the event had the greatest impact on you and why?**

Opening speech very informative
Hand massage
Diversity of service on display
The overview of the new operating model
Good description from speaker of how we can all work together and prevention is better than the cure
 **Please tell us specifically how this learning will:**

**Improve working practice**Assist me to help customers from a signposting complaint point of view
Know what’s available
Getting lots of information
I feel I am already working in a preventative manner

**Improve service delivery**I agree that emphasis on prevention is essentialImproves my knowledge in changes in social care

**Achieve outcomes for service users/customers**I believe this method of working will be beneficial , but we need to be aware of service users who are already needing a high level of care / support and have not had the benefit of re-ablement

**Sharing your learning:**

**Who do you intend to share this learning with and who else could you consider, outside of your immediate team, the share the learning with?**Provider agencies would benefit from this
Work colleagues and ILC visitors
Customer Care Team

**What specific learning elements do you intend to share?**New model and how it’s changed from previous service delivery
Benefits of re-ablement and continuing in an enabling way
 **How do you intend to share this learning?**Discussions and Information
Through practice
Team meeting **Please tell us what would have improved the experience for you and any additional comments you wish to share**Central location, Town Hall would have seen more staff attend, who do not drive and staff could have popped in – venue to distant

This was an excellent networking opportunity which will enable the Trust to work closely with services users / carers to seek their oppress on services

**Quiz - Answers** (Unfortunately there were no winners for the quiz)

1. What is included in the standard Telecare package available to people in Walsall? (Choose 3)

|  |  |  |
| --- | --- | --- |
| 1. Pill dispenser
 | 1. Smoke detector
 | 1. Key safe
 |
| 1. Bed sensor
 | 1. Flood detector
 | 1. Pendant alarm
 |

2) What percentage of Walsall residents do not smoke?

|  |  |  |
| --- | --- | --- |
| 1. 75.5%
 | 1. 53.8
 | 1. 5%
 |

1. Walsall’s Independent Living Centre (ILC) is a facility for disabled people, carers, older people and professionals who offer support and advice on independent living issues. The centre specializes in up to date equipment for the home and information on a variety of disability-related topics.

Which of the following is not offered at the ILC? (Choose only one)
A) Shopmobility and wheelchair loan services

1. Reflexology
2. Sensory support information and advice
3. Telecare equipment and demonstrations
4. Occupational Therapy advice
5. Walsall Council’s welfare rights team is responsible for delivery of its service to all residents of the borough; they offer a home visiting service to all which resulted in gaining the residents of Walsall how much income last year 2012/13?

|  |  |  |
| --- | --- | --- |
| 1. £8.9 Million
 | 1. £10.8 Million
 | 1. £9.2 Million
 |

1. Community Associations work in close partnership with local people, providing vibrant, locally run activities, sports clubs, older people’s services, life-long learning opportunities, youth groups, promoting volunteers and contributing to improving the quality of life in its areas of benefit. They are the largest providers of part-time adult education and recreational classes in the borough.

How many community associations are there in the borough?

|  |  |  |
| --- | --- | --- |
| 1. 17
 | 1. 22
 | 1. 9
 |

1. How many people are estimated to have dementia in Walsall?

|  |  |  |
| --- | --- | --- |
| 1. 2,850
 | 1. 4.050
 | 1. 3,350
 |

1. Community Social Work team and Neighbourhood Community officers supports citizens who have low level care needs to stay independent longer, utilising resources within their own community. The team primarily concentrates on prevention of dependency and promotion and generation of local resources. Working in line with the Personalisation agenda they develop and promote community resources so that the citizens can receive the support from within their own local areas and continue to stay in their own home environment.

Which of these do they not do? (Choose one only)
A. Organise furniture and funds

 B. Assist to Bid on properties

C. Benefit checks

D. Assistance with form filling (blue badge, refer on for fire checks)

E. Assist self funders with organisation of care under 10 hours including day care

 F. Set up direct debits and meal services

 G. Install Telecare equipment

1. How many people are estimated to have diabetes in Walsall?

|  |  |  |
| --- | --- | --- |
| 1. 16,318
 | 1. 15,412
 | 1. 13,719
 |

1. There are eight strands to the operating model, here are six. Can you name the missing two?

|  |  |  |
| --- | --- | --- |
| Universal services | Universal interventions | Targeted Interventions |
| Assessment | Go Live | Review |

First Contact and Support Planning

1. Initial Referral Officers (IRO) are 1st port of contact for all Social Workers, Occupational Therapists and the Sensory Support team. Their role includes signposting, completing referrals and giving out a range of information

Where are they based?

|  |  |  |
| --- | --- | --- |
| 1. Streets Corner
 | 1. Civic Centre
 | 1. Allen’s Centre
 |

**Thank you to everyone who took part in the quiz**

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**Celebration Stories**

30 People shared on our Celebration wall, It is fantastic to read about some of the hard work that is being done by our colleagues.

**Team Name:** **Customer Care Team**

**Our Achievements:** This first half year the number of complaints has slightly decreased from 47 in 2012-13 to 46 in 2013-14 and there has been a significant increase in the number of compliments for the same period rising from 46 last year to 105 this year to date.

**Team Name:** **Independent Living Centre**

**Our Achievements:** Mrs J came to the ILC with her daughter and granddaughter to ask about the possibility of having a shower room fitted at home. She has breast and bone cancer and also has dialysis 3 times each week due to kidney failure.

She was given information regarding Social Care but she stated that her family are happy to continue to assist her at present

I rang her GP from the ILC as she still had stitches in situ in a wound from surgery in April. The wound looked infected. The family had thought the stitches were meant to dissolve but this hadn’t happened.

This lady had been discharged from hospital with a terminal diagnosis but with no support from any services. Her granddaughter had suggested she visit the ILC for assistance.

I completed an assessment with her for bathing equipment, this was not suitable so a referral for a Disabled Facilities grant for a level access shower was completed and sent to Housing.

Mrs J was also struggling to manage stairs so I assessed her on the stair lift in the ILC and included this provision on the DFG request

Following discharge from hospital Mrs J had been sleeping downstairs with a baby monitor so she could call for help if necessary, she desperately wanted to go back to sleeping upstairs with her husband.

A phone call was also made from the ILC to the MacMillan Nurses to request they follow up this case.

**Team Name:** **Adult Safeguarding Unit**

**Our Achievements:** The Walsall Safeguarding Adults Partnership Board adopted the Safeguarding adults: multi agency policy and procedures for the West Midlands in April 2013. The benefit to adults at risk (and their families) is the increased understanding of a preventative approach and where required an appropriate response to address the concerns raised.

**Team Name:** **Supported Employment**

**Our Achievements:** Employment Services, which comprising Links to Work and Recruitability continues to provide real work opportunities for disabled residents of Walsall. Over 150 individuals have been employed on the Recruitability programme in a variety of roles, both within the council and our external partners. As a result, a significant number of people who have finished the programme have moved into sustainable paid employment, while others continue their personal development through volunteering opportunities and further education. The success of the service has meant Walsall Council is one of the leading authorities in the region for Disability Employment.

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**Team Name:** **Independent Living Centre**

**Our Achievements:** Master B came to the ILC with his mother requesting a shower for over the bath. He has chronic bowel problems and has stoma fitted, he needs to use a shower as he could not sit in water due to the risk of

This case was joint worked with the Adaptations Coordinator, Chris Howes, who liaised with the family’s landlord, WHG. An over bath shower was fitted and completed in two weeks whilst Master B was in hospital

**Team Name:** **Sensory Deaf Team**

**Our Achievements:** Mr C – Profoundly Deaf without Speech, British Sign Language user and has mental health.

Mr C – Has been in an out of a specialist mental health hospital for Deaf people over the last few years. Mr C was refusing to have his depot injection and take his medication when living in the community. Mr C could not manage his finances and would never have any money for food. Mr C was also socially isolated.

**Outcome Achieved** –

Support worker worked on a 1-1 basis with Mr C they discussed and gave advice as to the importance of having his depot injection on a regular basis and for him to take his medication. This ongoing work has prevented Mr C from returning to hospital. Mr C has not had to return to hospital in the 2 years. Support workers have also educated and supported Mr C to obtain a computer/laptop with a webcam facility. This is important to Mr C as he is now able to keep in touch/communicate via his webcam with the Deaf Community; especially with his friends.

**Team Name:** **Independent Living Centre**

**Our Achievements:** Mrs G came to the ILC with her son for a Blue Badge assessment. The assessor for blue badges asked me to speak to this lady re her mobility issues. Her husband had passed away one month earlier and he was a hoarder. Her son and brother were trying to sort out the property as she was unable to access the bedroom and had been sleeping on a riser recliner chair. We discussed how this was not good for her but at that time she was unable to get up stairs.

I assessed Mrs G for a walking frame and a trolley. We discussed and tried the stair lift at the I.L.C. and I then made a referral to Housing for a Disabled Facilities Grant

We talked about preventative adaptations, funding available via Housing for non DFG eligible adaptations, and they were very happy for me to refer them to Housing for this to allow them to have a ground floor WC fitted.

I also gave them the Silver Service telephone numbers who help with odd jobs. And the social care telephone number should she need more help.

Her son rang to say that bedrooms and garage cleaned out and getting ready for stair lift.

**Team Name:** **Reprovision Team**

**Our Achievements:** E – 53 year old woman with moderate to severe learning disability, physical disabilities, permanent wheelchair user, lacks mental capacity in some areas, but has capacity in others.
E was living in a residential care home out of borough, her family who live in Walsall were dissatisfied with the care home, and E was stating she wanted to move into her own flat.
 Working with the NHS Learning Disability Team, including; Occupational Therapy, Physiotherapy, Behaviour Support, Speech and Language Therapy, Nurses, and Consultant Psychiatrist, re-assessments commenced. It was agreed that E had Mental Capacity to make the choice to leave residential care
E has challenging behaviour which impacts upon others was a main area for concern, and it was recommended by all those involved in assessing her that she live alone rather than share with others.
E moved into her own flat in central Walsall in mid 2012, with a Live in Carer, and four double up calls each day as she needs hoisting for all transfers.
The outcome is that she now has control over who she employs, and although an agency has been given the contract to support her at the moment, her family and friends may change to direct payments and PA’s in the future if it is not working out with the agency. She can direct the care herself, and issues around having to wait whilst the needs of others were attended to are no longer an issue. She lives closer to her mother and friends in Walsall.

**Team Name:** **Sensory Deaf Team**

**Our Achievements:** Mr A – Profoundly Deaf without Speech and communicates using British Sign language.
Mr A - Was made redundant; his previous job was a jewellery polisher in the Jewellery Quarter, Birmingham.
Support workers liaised with Job Centre Plus and other job agencies to ensure they provided a sign language interpreter and that they were aware of Mr A needs as a Deaf person. Support was provided to refer Mr A to a specialist job agency called Clarion Ltd in Birmingham they were able to provide a service to help Deaf people find and keep jobs, they have staffs whom are Deaf and are able to communicate in B.S.L.

**Outcome Achieved** –

Mr A is now in full time employment.

**Team Name:** **Reviewing Team**

**Our Achievements:** Miss B is a younger adult with learning disabilities and she is 50years old. Miss B has been attending Links to Work for 3days/week for over 5 years. Following discussion with Links to Work, I understood that Miss B was not suitable to move onto paid employment due to her health issues and functioning. I looked into option of Miss B moving into voluntary employment through Mencap which she declined.  After some amount of discussion, Miss B agreed to access a local lunch club which connects her to her local community. It also offers her opportunity of offering her services on voluntary basis when at the lunch club. Miss B has also been linked to a day centre where she will attend 2hours/week. She will however be able to access their day trips as and when she wants. This offers Miss B wider opportunities in meeting her social needs instead of her over reliance on the social aspect which Links to work offered her.
Miss B was also receiving the input of a Support worker once /week with going to the shops and also attending hospital appointments. Miss B has now been linked to Liaison Nurse at Manor Hospital and the Voluntary services who will assist her in attending her hospital appointments instead of relying on a paid carer. Miss B will also be supported by Keyring together with another key ring member in accessing the shops
In all, my input has helped in reducing Miss B ‘s reliance on paid services, promoted her level of confidence and supporting her to connect with her local community.

**Team Name:** **Walsall Shared Lives and Adult Placements**

**Our Achievements:** Our more interesting positive news stories include service users living in long term placement with our carers enjoying a range of foreign holidays. One service user with multiple disabilities enjoyed swimming with dolphins whilst another enjoyed swimming in the warm Mediterranean sea for the first time off one of the Greek islands.

**Team Name:** **Quality Assurance Team**

**Our Achievements:**

* Establishment of the ‘Hearing the voice’ sub group to elicit views and experiences of carers and people who use care services
* Establishment of a care visitors scheme with the Vine Trust
* Involvement of CUSP in the Incentive Scheme Award Panel to ensure that the voice of care home residents is taken into account
* Presentation on role of LINK and agreement on the referral process for reporting of concerns
* Designed and implemented systems to measure and recognise quality in care services
* Approved incentive scheme bids include development of the visitors scheme and a sensory garden at a care home
* Closer monitoring of trends and poor practice has informed decommissioning of failing providers
* Informed the development of a focussed training programme, which is now available to care providers

**Team Name:** **Walsall Councils - Health and Fitness team**

**Our Achievements:** The Health and Fitness team are regularly highlighted locally and nationally for their good work. Most recently the WAY team won health improvement initiative of the year at the 2009 Black Country sport and physical activity awards, for their success with the Fun4life programme. They beat off competition from the nationally recognised MEND programme. Also the Walsall Walk On programme has been accredited by Natural England and was highlighted for best practice.

**Team Name:** **Complex Team**

**Our Achievements:** Mr H is a young man who suffers with severe epilepsy. Most of his care needs are supported by his mother, who lives with him at the family home. His father died about six months prior to my involvement. He does have support through a PA, to give mum a break.
Mr H had very little social life, as the needs of his condition dictated that he needed someone with him at all times.  He really liked fishing, but had not had any opportunity for this since he was a lad, when his condition was not so severe, and his father used to take him.
Having discussed Mr H’ situation with colleagues we put together a micro group of likeminded individuals, (Service users), who also wanted to go fishing. We arranged for them to meet and discuss how the group would interact, given their different needs, and how they would summon help if needed. Each person brought with them a skill which would help the group as a whole.  This enabled Mr H to participate independently without paid support, and to contribute to the wellbe ing and efficiency of the group

**Team Name:** **Strategic Development Team**

**Our Achievements:** We have now supported the initiation of 56 Micro Supported Services

**Team Name:** **Welfare Rights Team**

**Our Achievements:** Welfare Rights Service had another successful year where we continued to offer a personalised service for the benefit of Walsall residents whilst strengthening its economy through income generation.

* 10.8million in new benefit claims for residents 2012/13
* £1.3million gained for carers and their family through the Carers Project in 2012/13
* Approximately £3.8 million can be invoiced following our benefit based charging assessment for domiciliary and day care services used. 2012/13.
* 7741 Referrals dealt with in 2012/13
* From referral total above the average gained per referral equals £1390
* £3149 per financial gain through welfare take up and benefit maximisation
* Debt team achieved recognised qualifications from the Institute of Money Advisors.
* 351 Advice sessions delivered throughout the borough in 2012/13, a 24% increase on the previous year.
* 80% success rate at appeals to the tribunal service compared to one third success rate nationally.

**Team Name:** **Goscote Greenacres Gardens**

**Our Achievements:** Goscote Greenacres Community Gardens are running at full capacity with 52 plots on site in use. The clearing of the canal side and launching of Goscote Greenacres Fishing club has been a much needed resource in the local community, and it now has 22 members. They will be holding their second fishing competition on the 2nd November after the success of one earlier this year. The site offers exclusive access to the canal side, use of toilets, car parking and use of the Community Cafe Monday to Friday. Greenacres is run in Partnership with the Greenacres Committee which is made up of local residents and everyone has worked extremely hard to make the Greenacres a success.

**Team Name:** **Complex Team**

**Our Achievements:** The Complex Team works with individuals, as well as their families, carers and support networks, who require longer term Social Work input. We work in person centred and creative ways to promote independence and support people to achieve their desired outcomes. We are a generic team so there are opportunities to work with individuals of various ages with a range of unique abilities and aspirations. We work collaboratively with other colleagues within social care and partner agencies. Our assessments and support planning with people is completed in line with the personalisation agenda and innovative operating model in Walsall. We undertake a high volume of complex work, including safeguarding, transition work and forensic work. The Complex team is a very busy team but the work is exceptionally rewarding and undertaken in a very supportive environment, both within the team and with our partners

**Team Name:** **Sensory Deaf Team**

**Our Achievements:** Mr B – Profoundly Deaf without speech, physical disability and communicates using British Sign language.

Mr B - was finding it very difficult to maintain his personal hygiene and hygiene in his home was very poor. He was struggling to clean his flat, wash his clothes, change his bed clothes and go out to shop for foods etc.

Support Workers did some research in obtaining a suitable PA (personal assistance) who has Sign Language skills and could communicate with Mr B in his preferred method of communication.

**Team Name:** **Independent Living Centre**

**Our Achievements:** Health and Social Care Teachers visited ILC with two main difficulties:

* They were unable to show the students pieces of equipment discussed in class

AND

* While they were able to provide the theory relating to health and social care they struggled with students developing a personal understanding, for example, students were able to recite care values but had difficulties recognising them and applying them in case studies

Two School’s Day formats have been executed; an older people study day and a care values study day.

* 100% of respondents involved reported that the day enhanced their awareness of older people/care values.
* 23 written compliments and thank yous received by staff from participants in school day.

Student’s comments from the evaluation sheets include the following:-

* With regard to the learning experience:
	+ *It was a different way to learn*
	+ *I enjoyed...being put out of my comfort zone in order to understand*
	+ *I have learnt more because I have seen it face – to – face rather than looking in a book*
	+ *This will help improve our coursework*
	+ *It made me realise that their is things out there to help people*
* With regard to personal growth:
	+ *It’s really opened my mind on how I see people and judge people It’s taught me to be more patient and polite/helpful*
	+ *Just looking at someone doesn’t show how they feel inside*
	+ *From this day I will not push past old people and be more patient with old people and people in wheelchair*
	+ *It made me more aware of how people feel when the care values are used correctly and not correctly.*
	+ *It made me realise how little respect is given to the less able*
	+ *I will be more considerate in future*Benefits
* Forging strong links with the community.
* Providing positive experiences for young people and enhancing their learning in terms of their understanding of disability and services available.
* Providing a safe and relaxed environment for experiential learning for example wearing the age suit, simulation glasses, using wheelchairs and talking to people with disabilities.

**Team Name:** **Reviewing Team**

**Our Achievements:** Mr H is a young man who suffers with severe epilepsy. Most of his care needs are supported by his mother, who lives with him at the family home. His father died about six months prior to my involvement. He does have support through a PA, to give mum a break.
Mr H had very little social life, as the needs of his condition dictated that he needed someone with him at all times.  He really liked fishing, but had not had any opportunity for this since he was a lad, when his condition was not so severe, and his father used to take him.
Having discussed Mr H’ situation with colleagues we put together a micro group of likeminded individuals, (Service users), who also wanted to go fishing. We arranged for them to meet and discuss how the group would interact, given their different needs, and how they would summon help if needed. Each person brought with them a skill which would help the group as a whole.  This enabled Mr H to participate independently without paid support, and to contribute to the wellbeing and efficiency of the group.

**Team Name:** **Community Social Work Team
Our Achievements:** Community Social Work Team support citizens who have low level care needs to stay independent longer utilising resources within their own community. The team primarily concentrates on prevention of dependency and promotion and generation of local resources. We identify local resources, Community organisations, local groups and third sector partners and build up a link between these resources and citizens. We aim to create a self dependant community with local resources and service to meet their own needs.

**Team Name:** **Community Bases**

**Our Achievements:** Offer day opportunities for adults with learning disabilities in their local communities. Activities are person centred and focus on enabling individuals to peruse meaningful activities and pursue their hobbies and interests. These are done in through a consultation process so that individuals are enabled and empowered to make choices and express preferences on how they would like to spend their time when they are with us. Some of the opportunities they can become involved in which we would like to celebrate as achievements include:
 Coffee mornings and fund raising events in partnership with local community associations to raise funds for local projects, and national and local charities.
 Running local Charity shops to raise funds for local projects and initiatives which include the Charity shop in Pelsall where the funds go toward the Pelsall High Heath Youth Charity Association which fund projects for the local youths in Pelsall.
 Accessing local shops to buy personal items or replenish stock for the base, places to eat, visiting libraries to access intranet to do research, going to leisure centres to do keep fit, and visiting places of interest. These activities enable individuals to develop social networks, and become familiar with their local communities.
 Pleck Community base have a Breakfast Club every Wednesday morning between 10.30 and 12.30 offering a full breakfast and make sandwiches. This is open to everyone in the local community for a reasonable charge.  This has been up and running for about 12 months now and it has been a huge success in supporting the Community base and the local community.
 It has encouraged inclusion and active participation into the local community.
 Crafty Tuesday is an Art and Craft group also run from Pleck Community base where the local community to come together to gain greater skills and knowledge in art and crafts.  It is professionally tutored and enables individuals to develop their skills as well as acquire new ones.
 Community Bases have Made links with Darlaston Active to support customers to access different areas and sessions within other environments of the local community to gain new experiences and opportunities, as well as broadening their circle of friends.
 Most of the bases also provide exercise sessions which are run by the Health service and enable individuals to exercise and learn how to maintain healthy lifestyles. Individuals can talk to professionals about any concerns they have in a confidential and supportive environments. These sessions promote partnership working and looking at holistic outcomes for individuals.
 Everyone accessing the Community Bases has access to Community allotments where they can grow their own produce in order to use in cooking recipes or to make jams, chutney’s or pickles etc. Horticulture is also extended to caring for green spaces around building, as well as being involved in community projects such as the Moorcroft project in Bilston.
 Rushall Community base have a very pro-active Drama Group that puts on a major productions every year. This year the theme is around Jungle book. Productions have received compliments from the Mayor, carers and many others who have seen them.
 Friends Together is a Social Group where individuals meet once a month to see their fiends over a nice cup of tea or coffee. The group encourages positive relationships and has regular events to facilitate community participation. It is extremely popular and everyone looks forward to this.

**Team Name:** **Independent Living Centre**

**Our Achievements:** MRS X visited the I.L.C.as she was very stressed with her situation at home caring for her husband who has vascular dementia. She came in with her daughter and stated she felt like the system had let her down. Her husband was given the diagnosis and then she had been just left to care for him with no support .
We discussed the assessment and asked them to bring him in to the ILC. We discussed the dementia cafe held at the ILC on the first Friday of every month. Mrs X attended this and received more information and help regarding to coping mechanisms she can use, equipment and who to call for help .
Mr X came to the ILC and we assessed him at that time with help from his wife. MR X is doubly incontinent, we discussed the fact that she was purchasing carpet for the bedroom as he has many accidents with continence we talked about having lino fitted so that she could mop, and this would not cause her so much anguish . Also his wife can no longer get him into bath he has lost his ability to sequence how to lift legs and get in and out we tried equipment but this was not suitable and appeared to confuse him more. We discussed the disabled facilities grant and this was applied for and accepted on AUGUST 1ST .2013.
Carers assesment requested on paris and benifits check requested on phone from ILC also advised that drop in sessions are on a wednesday 2 till 4.
After discussions a few weeks later Mr X attended Watermill Dementia Unit, his wife went with him the first time but he now attends on his own. Mrs X came back to the ILC to say he attends two days a week now and he loves going and she now has time to rest.
The shower is due to be fitted at home in the near future and Mr & Mrs X continue to get support from the dementia cafe. Mrs X is changing the bedroom carpet for lino and is no longer stressed by having to clean the carpet, Mr X has been referred to the Continence Service for further assistance.

**Team Name:** **Sensory Deaf Team**

**Our Achievements:** Mrs D who is in her 50’s is profoundly Deaf without Speech and has cerebral palsy. Mrs D uses an electric wheelchair to mobilise when outdoors. Mrs D lives in a three bedroom house with an adapted lift which is situated in the lounge; this lift goes up through the ceiling up into her bedroom. The lift started to breakdown on quite a few occasions, Mrs D is unable to make a telephone call to the repair services as she is profoundly Deaf. On one occasion Mrs D had to slide on her bottom down the stairs to send a fax to the support worker in the team.
Mrs D mobility started to deteriorate and it was no longer safe for her to continue living at this property. Support workers in the team were involved and started supporting Mrs D to register and find a more suitable property to live in.
Outcome Mrs D was offered a new build ground floor flat, near to Walsall town Centre. This property now has all the specialist equipment required such as widened doors, a fitted hoist in her bedroom, lowered kitchen worktops, electrical front opening doors etc. Mrs D is now happier, socialising more and has saved a considerable amount of money on taxis as she is now 2 minutes from Walsall town centre.

**Team Name:** **Recent re-design of service at Goscote Greenacres**

**Our Achievements:** We now have a new Activity programme that has been designed in consultation with customers, carers and key workers
**Sensory Room** – a safe and stimulating environment that creates a stimulating yet calming environment. Sensory equipment includes items such projectors, bubble tubes and fibre optics. We are also working in conjunction with the Occupational Therapist who is able to carry out individual sensory assessment for our customers. This is particularly beneficial as it can highlight any sensory difficulties people have such as being over sensitive to light
**Opti-Music system**- A unique audio-visual system that is played by interacting with coloured light beams – any movement within the beams triggers a sound. This is situated within our sensory room
**Music Therapy** – various music activities including large and smaller singing groups use various musical instruments, key board sessions, music sessions within the Opti-Music / sensory room and also designing and making their own musical instruments. Interactive story sessions are also offered within these sessions
**Cookery** – a fully equipped training kitchen with a variety of adapted equipment. Customers can enjoy participating within cookery sessions making a variety of sweet or savoury foods as well as enjoying the sensory aspects of sessions such as various textures and smells. In addition to the above customers gain an awareness of safety in the kitchen and food and hygiene skills
**Art and Craft** – customers enjoy art and craft activities using a wide range of materials including paints, pastels, clay and various textiles. Art projects include making masks, cards and collages.
**Exercise** – a variety of exercise and activity sessions appropriate for the individual’s needs and abilities including gentle exercise sessions, using the parachute, ball games, indoor bowling, Extend sessions, and Tia Chi. We are also working in conjunction with the Physiotherapy Therapist who provides physio programmes to meet the needs of the individual.
**Therapy Sessions** – therapy sessions include music and relaxation, hand and foot massage, aromatherapy, foot spa’s, water bed sessions and sand and water therapy
**Communication** – a variety of structured communication activities are offered aimed at maintaining and increasing customers effective communication skills. Activities include sensory communication sessions – using various sensory equipment items, to encourage customers to express likes and dislikes, make choices and ask for more.
**Computer sessions** using adapted equipment such as ‘Big Tracks’ with programmes such as cause and effect programmes, picture building and programmes to reinforce recognition skills.
**Card making sessions** using a total communication approach (using real items, photographs, pictures, symbols and signs) customers use these to identify and find equipment, follow instructions and make choices.
There are other structured communication activities offered, however, at Goscote we are working towards using a total communication approach during all activities and on a daily basis.
 We now have a visual time-table for our customers situated in a central location where they are able to see what activities are being offered within the various rooms on that particular day. We also have a pictorial, interactive calendar and customer notice board where information is presented in an appropriate format. We are also working towards using visual time-lines within all sessions. **Autism** – the Autism befriending group meets at Goscote Greenacres and there is also an Autism adult social group that meets on the first Wednesday evening of every month.
**Links with Hawbush College** – students from Hawbush college attend our commercial kitchen at Goscote where they are working towards obtaining their hospitality and catering awards

**Team Name:** **Reviewing Team**

**Our Achievements:** Mr D is 72 years old. He suffers from depressive disorder and has had two strokes which resulted to right sided weakness. I first got involved with Mr D’s case to complete annual placement review. Mr D has lived 10 years in nursing placement and appeared to be unhappy at home. Mr D shared a small room with another resident and would sometimes use the commode when he was desperate for toilet and also when the other resident was present in the room. During the review I questioned Mr D’s eligibility for nursing care and the quality of care he was receiving at the home. Mr D stated during the review that he enjoys shopping and a pub meal. He bought himself a scooter to be able to access these activities with support but Mr D was not being supported to do so. He told me during the review that he was only taken out once or twice in the last 12 months.
I have discussed with Mr D the option to consider extras care housing and advised that these facilities might be able to cater for his needs and promote independence. Mr D was at first reluctant to consider this option. Due to poor mobility, Mr D was very concerned about leading an independent life and thought that he will be at risk of falls. Whilst Mr D was given time to think about extras care housing, the nursing home was forced to close following safeguarding investigation. Mr D then moved to extra care placement wit a view to reablement supporting and then consideration for a permanent tenancy. Mr D’s daughter at this point felt that this placement was not appropriate for Mr D and that were putting him at risk. Daughter was very concerned Mr D living on his own with poor mobility. OT and physio completed assessments and provided equipment needed, 4 weeks after Mr D was able to mobilise short distances on his own with a walking frame, he was supported by staff to access local shops and his son took him to the local pub once weekly. Mr D had a good quality of life during the time he spent at extras care placement. Unfortunately 12 weeks after, Mr D was diagnosed with Parkinson disease which rapidly affected his mobility and increased the level of support he required. Mr D has now moved in residential home near his daughter‘s house. He enjoys time with his daughter as she is now able to visit more often and his 15 years grandson rides his bike to see him almost 4 times per week.

 **Team Name:** **Reprovision Team**

**Our Achievements:** BB – 48 year old woman with moderate learning disability, history of very challenging behaviours. Has Mental Capacity.
B was living in an out of Borough placement with Castlebeck, essentially, a private hospital, where she had moved from St Margaret’s long stay hospital 20 years ago, she had been placed in Northumberland as this was the only placement at that time that could meet her extreme needs and because she had been subject to abuse by her family in Walsall there were no reasons for her to remain in this area.
B was re-assessed and it was discovered that the behaviours that she used to exhibit were no longer in evidence due to a combination of B’s mellowing over time, gaining the skills to manage some of her own anxiety, recognising the triggers herself and signs of anxiety building, also having a good behaviour management programme in place. B no longer met the criteria for being in residential care, saying she wanted to leave the placement where she was no longer happy to be as she found some of her anxieties were being heightened by the behaviour and noise of other residents, she stated she wanted a flat, but was clear that a move back to Walsall was something she feared because of the abuse in her past, she was now very familiar with the community near to her placement, and wanted to continue with activities in that area.
A two bedroomed property near to the day centre and leisure centre she attends was located. The Reprovision team ensured that benefits were maximised, tenancy was signed, furnishing of property arranged, and a live in carer was located via an agency. B was fully involved in the planning of her move as she has capacity, and chose her own live in carer.
The live in carer has times during the day that are designated her down time, she spends this time within the property in her own bedroom, allowing BB to have some privacy, but with the security of knowing there is someone present if she needs assistance.

**Team Name:** **Sensory Deaf Team**

**Our Achievements:** Mrs A was completely at loss when her husband died, she had a lot of difficulties in getting grips with her finances; Mrs A had never really had much to do with the finances as this was always left for her late husband to deal with. Our team (Deaf/Deafblind Team) assisted her in regards to notifying various departments and assisting with her financial issues, i.e. bereavement allowance and to inform the benefits section to stop her carer’s allowance payments as Mrs A was unable to access services or contact any agencies independently due to her disability. Staffs listened and sympathised with Mrs A while she was grieving and suggested she went for counselling. We were there to support at her hour of need, and prevented isolation.
**Finances Issues** - Mortgage and insurance, we have had to educate Mrs A in regards to her budgeting as was spending quite a bit of money on catalogues items and owed thousands of pounds. We explained and educated Mrs A as to what it meant by ‘interest rates’ and that she needed to reduce her spending and be more careful. We drew up a basic/visual expenditure chart monitoring her income and outgoings. Mrs A began to get a clearer picture of how things operated and also often complained about how her friends were getting more income/benefits than herself. We explained that the reason being is that Mrs A was in receipt of a private pension from her late husband which put her income over the minimum threshold so this meant that she would not be entitled to all of the full benefits that her friends were receiving. Mrs A has now drastically cut down on her spending habits, but still has the occasional treats and Mrs A is now able to monitor/manage her finances independently.
**Housing Repair** Mrs A had an issue whereas her house as the roof was in need of an expensive repair which she was not in a position to finance this. Staffs sourced some charities that could assist and it was agreed that a charity would contribute to the cost towards the roof. The roof was fixed.
**Medical Fear** Mrs A has a terrible fear of the dentist and had a bad case of toothache! Gentle encouragement and a few appointments of staff holding her hands, Mrs A can now attend regular dental appointments on her own. Mrs A had issues with her eyes and needed treatments; we assisted with arranging transport to and from the hospital and we arranged that a Sign Language interpreter to be present for all her appointments. This was to enable Mrs A to keep fully informed about what was happening with her eyes. This was a big issue for Mrs A as she has struggled to cope with one eye as the other has deteriorated quite quickly which has resulted in a vision loss. Mrs A became fearful of getting out and about for the fear of bumping into things, crossing roads and not seeing cars coming, A Cataract operation was performed on her good eye to improve the vision and this has helped. There was still a fear of getting out and about but this has greatly improved until the beginning of last year when she suffered a fall. This has greatly shattered her confident. Slowly with the help from the Fall Prevention team, healthy eating and exercise, Mrs A is feeling better and more confident again.
It has now been agreed with Mrs A that her support will be reduced to once a month. Mrs A is able to access the drop in duty service that is available for Deaf B.S.L users to access Monday – Friday.

